DOCUMENT RESUME

ED 308 655 EC 220 519

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TITLE An Aversive Issue...Which Refuses To Go Away.
PUB DATE Nov 88
NOTE 8p.
PUB TYPE Viewpoints (120) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Behavior Disorders; *Behavior Modification; Civil Rights; Decision Making; Due Process; Ethics; Intervention; *Punishment; *Self Mutilation; *Severe Mental Retardation; Training Methods
IDENTIFIERS *Aversion Therapy

ABSTRACT

Chronic self-injury is a psychopathology which afflicts some persons with severe mental retardation. The self-injurious acts may be carried out to avoid completion of a task, or the behavior may be intrinsically reinforcing. Professional responses have included use of restraints, psychopharmacology, placement in more restrictive settings, and engaging the children in alternative activities. If all reasonable positive approaches have been tried and found to be unsuccessful, aversion techniques are called for, such as the SIBIS cloth helmet which delivers a shock to the arm following a self-injurious act. In many facilities, de facto elimination of the use of aversives has occurred due to the facilities' fear of lawsuits against them. A careful weighing of costs and benefits should be done on a case-by-case basis to ensure that the client's right to treatment and a better quality of life are not denied. A two-phase process is advanced to maximize the chance of treatment success and the social integration of the client: (1) a rigorous process should be established to guarantee that intensive nonaversive procedures are tried before a committee recommends use of aversive therapy; and (2) implementation of aversive procedures should be overseen by a national board of certified professionals. (JDD)

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FROM THE EDITOR

AN AVERSIVE ISSUE ... WHICH REFUSES TO GO AWAY

Robert Gaylord-Ross

The sight of a child banging his head repeatedly against a table or a refrigerator will cause the most stoical to emote. In my own case, I was initiated to the sight of self-injury when I dealt with a Down Syndrome youth who continuously dug his fingers into his ears. Chronic self-injury is a psychopathology which afflicts some persons with severe mental retardation. It may include a wide variety of behaviors from head banging to self-scratching, to the most common -- punching or slapping one's head. The self-injurious behavior usually appears frequently on a daily basis. Thus, it is not like the self-destructive acts of suicide or masochism which occur episodically.

Besides describing this bizarre form of behavior, relatively little else is known about its cause or treatment. Different biological and developmental notions have been advanced, but little support has been garnered from them. The concepts of positive and negative reinforcement drawn from behavioral learning theory have accumulated the most evidence to explain some forms of self-injury. For example, teachers and parents may give these children a command to complete a task or chore. The child may then emit a self-injurious act like head-butting until the teacher leaves them alone and does require them to complete the activity. This "avoidance" explanation has been shown to be operative in a number of self-injurious cases. Yet, there remain a number of children, often the most serious cases, which do not appear to be under the control of external events like parental attention, escape from demands, etc. The act of head-banging, for instance, seems to be intrinsically reinforcing. Even though the child may be bleeding or crying from the pain produced by the behavior, there simultaneously appears to be a pleasure component of these acts. Dr. Ivoor Lavaas of UCLA has described these children as being "addicted" to their self-stimulatory behaviors.

In spite of our limited knowledge of the cause of self-injury, psychologists and educators have been faced with treating these individuals. Unfortunately, the most common professional response has been consternation. With no treatment remedy at hand, many of these individuals have been restrained through mechanical devices like straitjackets so they do not harm themselves (it is not uncommon for individuals with severe self-injury to blind themselves through continual eye-poking). Psychopharmacology has offered another form of restraint as the individual is sedated to a level of inactivity so that they do not self-injure or display any other kinds of behavior. Also, as a result of the unseemliness of seeing someone hurt themselves, as well as the profession's limited ability to successfully treat these cases, the child is often placed in a more

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cloistered setting, like a state hospital or a segregated school. As we will see, the tendency to place untreatable cases of self-injury into more restrictive settings interacts with the ideology and policy of the professional community's response to treatment options.

Progress in Education and Treatment

In spite of the dismal picture just portrayed of our understanding and treatment of self-injury, there have been a number of advances worthy of note in this field . At the educational level, students with severe disabilities have been increasingly placed in more integrated public schools and community settings. This "normalization" has enabled many children to learn and play like nondisabled peers. Rather than sitting on a hospital ward with little to do, they become actively engaged in their school and community. A considerable body of research has shown that just being engaged in alternative activities tends to preclude the appearance of self-injury and other problem behaviors. The old adage of "keep them busy" appears to have some support in the treatment of this behavior. Furthermore, special education is now more uniformly offering programs for younger children. Thus, getting preschoolers involved in preacademic and social activities appears to prevent or limit the appearance of some forms of self-injury. Thus, "keep them busy from an early age" appears to hold much merit and promise. Equally important, severely disabled students served in integrated school programs appear to learn some of the language and social skills of their nondisabled peers. They advance to a higher form of social functioning, and do not remain fixed at lower levels of self-stimulatory or self-injurious behaviors.

Undoubtably, the most exciting research and treatment in this area stems from the attempt to interpret the "meaning" of self injury. Drs. Mark Durand and Ted Corr of the State University of New York feel that many children are attempting to communicate to others through their self-injury. For example, a child might punch his chest and legs to get the attention of his peers. He might slap his face when frustrated with a difficult problem. Durand has developed an assessment scale which helps determine the communication value of self-injury. More ingeniously, Carr and Durand have tailored treatment programs which match the communication intent of the behavior. Thus, the student who is puzzled by a task may be taught to signal a teacher for assistance. The teacher may simplify the task or prompt the student to success. The student thus learns to communicate for assistance in response to his frustration, rather than to respond with self-injury.

Aversive Treatment

In spite of the numerous advances in the education and treatment of this malady, there still remains much disagreement about a particular type of procedure. The controversy surrounding the use of aversive procedures like shock, exercise or seclusion is beclouded by a number of factors. One factor relates to the profession's ability to successfully treat all cases of self-injury. Some educators, like Dr. Luanna Meyer of Syracuse University, believe that all cases of self-injury may be remediated through positive procedures like social integration, positive reinforcement, and leisure activities. Professionals just need to work more intensively on applying a sequence of non-aversive treatments until one or some combination of them works.

A differing view, espoused by this author, feels that we need to aggressively explore non-aversive procedures with each child. Yet, in some cases the individual will not be rid of his self injury through this positive approach. Often, if all reasonable positive approaches have been tried and shown to be less than successful, it may be necessary to to try out an aversive technique.

Quality of Treatment

Unfortunately, the issue of whether aversives work and are necessary is beclouded by another factor, the quality of the educational or treatment program. For example, more than one program has caused harm, injury, or death when applying an aversive technique. The problem was often not in the aversive procedure, but that the staff was not well trained and failed to deliver systematic treatment techniques, e.g., consistent reinforcement, accurate record-keeping. Also, less comprehensive programs may rush into the use of aversives before more positive procedures have been fully tested.

All would argue that a quality staff and practices are needed for behavior management, yet we might be assuming too much in the level of standards of practice that exist in our educational and treatment facilities. Thus, Mark Durand developed a barrier model to require programs, under judicial scrutiny, to demonstrate how controlled positive programs have been tried, and have failed. Only when such "obstacles of good practice" have been cleared, may a professional team consider moving to an aversive treatment.

The Intractable Case(s)

If the quality of good service delivery could be guaranteed, many professionals would admit (at least in their private if not public statements) that there are a number of serious cases of self-injury that can not be successfully treated with non-aversive procedures (In fact, Dr.

Robert Hanner of the University of Oregon, the Director of a national research center on non-aversive treatment, has admitted that in public.). Given this fact, there has been a substantial record of the utility of aversive procedures. Almost 20 years ago, Lavaas gained notoriety by using an electric shock device to punish instances of self-injury. When treating children who sometimes emitted a hundred self-injury responses in an hour, with contingent electric shock Lavaas noted that self-injurious behavior ceased almost immediately. Replications of his work have established the effectiveness of this aversive procedure with the most serious cases. Furthermore, some parents and professionals feel that the costs -- a few instances of electric shocks -- are far outweighed by the benefits; a near permanent elimination of this damaging behavior. When aversive procedures work, the amount of pain and damage delivered by them is certainly less than that incurred by the chronic self-injurious behavior. A new technological advance in aversive procedure has recently been made by the SIBIS device. SIBIS is a cloth helmet worn by the child throughout his working hours. Any knock to the head by a self-injurious act leads to the immediate delivery of a shock to the arm. Dr. Tom Reischeid of Oklahoma State University has conducted controlled experimental research demonstrating the efficacy of SIBIS. The near total reduction of self-injury was not limited to a particular laboratory session. Since the headgear was worn throughout the day, it led to a far reaching suppression of the behavior.

Ethics and Treatment

The SIDIS device has led to a great deal of professional tumult. A number of advocacy and professional groups have called for its banning. Often, the main discussion revolves around the ethics of using aversive procedures. Advocates like Meyer would agree that it is inhuman to use an aversive procedure, stating that severely disabled individuals are the only group in which aversives are considered palatable. Thus, some groups advocate a ban on the use of aversive.

Such thinking is essentially misguided. For one, aversives are normally used in natural home settings. It may not be an ideal, but 20% of all noncompliances in American homes are met with physical punishment by parents. Furthermore, the Supreme Court has permitted the use of corporal punishment in the schools. Thus, aversives, whether desirable or undesirable, appear in our daily lives.

With regard to treatment, a number of clinical psychotherapies use contingent electric shock (to be distinguished from electroconvulsive shock therapy). Dr. Donald Meichenbaum of the University of Waterloo, for instance, has included the contingent shocking of a client to eliminate a number of stress-related disorders. Here, patients are of normal intelligence and willfully participate in the therapy. This contrasts with the aversive treatment of persons with severe retardation, who cannot

linguistically express their volition to participate or not involve themselves in a treatment. In this sense, it is not the use of an aversive, *per se*, which is the ethical issue, but the provision of an individual to *choose* to participate in such a treatment. Typically, a group of professionals makes a decision to involve a mentally retarded person in the treatment.

The Right to Treatment

Since the earlier work by Lavaas, the legal ability to use aversives to suppress self-injury has been successively precluded. Most facilities, whether state hospitals or public schools, have eliminated aversives like contingent shock from their treatment regime. This has resulted from the fear of lawsuits against the facility. Thus, even though there has been no statutory banning of the use of aversives (although many are calling for this), there has been a *de facto* elimination of the use of aversives in most settings. In a number of cases this has been a progressive development, as a number of safeguards (obstacles in Durand's terminology) have been set to insure intensive nonaversive treatment has been tried before proceeding to aversives. In the poorer cases, agencies have backed off from the consideration of using aversives. Whether *de facto* or statutory, when consumers (parents, guardians) cannot make a choice in selecting a particular therapy, their (the client's) right to treatment is violated.

There is also a practical outcome in the denial of the right to treatment. In the case where nonaversives have failed to suppress the behavior, the client continues to suffer physically and emotionally as he continues to self-injure, and the parents continue to suffer as they must witness and manage their child through this brutal condition. Ultimately, it is likely the family (and public school) can not manage the child, and he is placed in a more restrictive setting (a segregated school, a state hospital). Thus, the most difficult cases are swept out of sight to back wards of institutions. We professionals can continue operating under the illusion that we have community-based, integrated, non-aversive services. We will, and we do. But, behind the walls of institutional facilities, the self-injurious clients will be long forgotten.

The King Has No Clothes

The quality of services for persons with mental retardation has improved dramatically over the past 20 years. More and more persons live in their local community, rather than in state hospitals; they often attend integrated public schools; increasingly they are given the opportunity to work in real, rather than sheltered, settings. These reforms, if not revolution in services, were due primarily to unrelenting advocacy efforts and the emergence of a powerful instructional technology. The full

implementation of the integrated vision has yet to be reached. A major barrier to its implementation is the inertia and resistance of a segregated system and its professionals. In some cases though, our technology of treatment has failed to reach a sufficient level of proficiency. Seeming miracles have been accomplished, for instance, in placing a deaf-blind and mentally retarded individual in real, nonsheltered jobs. On the other hand, the field has yet to develop a technology of nonaversive treatment to succeed with all cases. One can certainly applaud the continual efforts to develop nonaversive procedures, and hope that one day all cases of self-injury can be successfully treated with this approach.

In the meantime, many advocates appear to suffer from the malaise of rising expectations. So much has been accomplished so rapidly. Yet, wish fulfillment to have the total integrated dream now may deny the right to treatment of many individuals in great need. It may make many people uncomfortable that an unpalatable procedure may have to be used. Yet, a careful weighing of costs and benefits should be done on a case by case basis to insure that the client's right to treatment and a better quality of life are not denied by some statute which soothes our professional visions.

A Proposal

A two-phase process is advanced to maximize the chance of treatment success and the social integration of the client. First, a rigorous process (a la Durand's obstacles) must be established to guarantee that intensive nonaversive procedures are tried. Increasingly, the field is setting up such review procedures to monitor the treatment process. Usually, a committee reviews treatment progress and recommends the consideration of aversives. At least one member of the committee should be a professional who has had extensive experience in conducting nonaversive behavior management. The committee should determine by majority vote whether to recommend an aversive. The consumer (parent, guardian) should have veto power in rebutting the use of aversives.

The second phase involves implementing aversive procedures. Since there is such a chance for poor practice here, local personnel should not oversee the treatment regimen. It is proposed that a national board be established to certify practitioners in the use of aversive procedures. Initially, only a small circle of the most eminent professionals would be certified to design and oversee the implementation of aversive procedures. Over time, an increasing number of professionals would be certified through this national board. Such a professional gate keeping process would parole the medical field's granting of board certification, as in such specialties as orthopedic surgery, neurology, etc. Such careful quality control over who can use aversives would safeguard the real potential for abuse or malpractice. The board would monitor and review professionals and cases under its jurisdiction. In fact, a first charge of implementing an aversive

would be to review past procedures and consider the application of some other nonaversive procedure. The diplomat in aversive conditioning would: 1) design a program; 2) guarantee the quality control of its implementation; 3) terminate the use of aversives if it proves ineffective, could not be delivered under stringent standards, or there appeared to be negative side effects; 4) program for the reinforcement of alternative, constructive behaviors and activities, e.g., language development, leisure activity; 5) program for fading and discontinuation of the aversive procedure; 6) program for fuller social integration of the client into the school and community; 7) program for the generalization of the elimination of the self-injury to other settings, people, etc.; 8) program for the maintenance of the treatment effects and provide follow-up monitoring and technical assistance.

A Personal Note

In preparing this article, I conducted two key interviews; one with Tom Reischeid and the other with Mark Durand. Each of them is on the cutting edge of technological developments in aversive and nonaversive technology. On the political spectrum, they are 180 degree adversaries on this most perplexing issue. Yet, I was struck by their similar personal and professional characteristics. Both were committed to developing a science of behavior which would eliminate the egregious problem of self-injury. They both articulated a fundamental feeling for the client's welfare. Reischeid described himself as someone who has used non-adversive methods and believes they can be successful in a great number of cases, yet feels the need for an aversive treatment option when warranted. Durand is committed to exploring communicative interactions and believes nonaversives must be pushed to greater limits than they are now in current practice; yet he would not rule out the use of aversives. It struck me as sad that such intelligent and empathetic professionals had to be on opposite sides of a sometimes ugly debate. In my own ruminations, I felt the need for a higher level dialectal synthesis of the best of Durand and the best of Reischeid. Hopefully, the two phase treatment process proposed here will point the field in the direction of eradicating self-injury and maximizing the opportunities for social integration for such unfortunate individuals.